WE HEALTH CLINIC
32 E 1st Street, Suite 300
Duluth MN, 55802
(218) 727-3352

Medical History—Abortion Services

Patient Name: _____
DOB: _____ Age: _____
DOS: _____

Name: _____ Legal Name: _____

Sex assigned at birth: _____ Gender Identity: _____ Gender Pronouns: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ OK to MAIL*? ☐ YES ☐ NO How did you hear about WE Health Clinic? _____

Phone #: _____ OK to TEXT**? ☐ YES ☐ NO *Bills, health communications **Appointment reminders, negative test results

This information is confidential. It is used for outside funding and statistical purposes.

Race: _____ Hispanic Origin: ☐ Yes ☐ No Education Level: _____

College: ☐ Yes ☐ No How many years completed: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ In a Relationship ☐ Living with partner

Job title: _____ Employer: _____ ☐ Full time ☐ Part time

Annual Income: _____ Number of people in your household: _____ Do you have health insurance? ☐ Yes ☐ No

Do you have Medical Assistance? ☐ YES ☐ NO If yes, what state? _____

Sources paying for your medical expenses: ☐ Savings ☐ Partner/Spouse ☐ Medical Assistance ☐ Private Insurance

ALLERGIES

☐ Yes ☐ No Do you have any medication allergies? If yes, please list: _____

☐ Yes ☐ No Do you have any other allergies? If yes, please list: _____

☐ Yes ☐ No Do you have a shellfish or iodine allergy?

MEDICATIONS

☐ Yes ☐ No Are you currently taking any medications? If yes, please list: _____

BIRTH CONTROL — methods you have used in the past, how long, any problems experienced

_____ IUD _____
_____ Nexplanon _____
_____ Pills _____
_____ Patch _____
_____ Depo _____
_____ Nuva Ring _____
_____ Condoms _____

Has a doctor ever told you not to take hormones? ☐ Yes ☐ No

Were you using a method of birth control at the time of conception? ☐ Yes ☐ No If yes, please list: _____

GYNECOLOGICAL/OBSTETRICAL HISTORY

Date of last Pap smear: _____ Was it normal? ☐ Yes ☐ No: _____ Where: _____

First day of you last NORMAL menstrual period: _____ Do you have a history of infertility? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

LIST NUMBER OF:	**DATES:**
_____ Live Births	_____
_____ Living Children	_____
_____ Miscarriages	_____
_____ Abortions	_____

Have you experienced any of the following with past pregnancies? If so, how many? Cesarean: _____ Ectopic/Tubal: _____

Premature labor/birth: _____ Stillbirth: _____ Twins/Multiples: _____ Genetic abnormality: _____

Patient Name: _____
DOB: _____ Age: _____
DOS: _____

HEALTH RISK HISTORY

YES	NO	
☐	☐	Do you feel safe in your relationship and in your home?
☐	☐	Have you ever been forced to have sex or been touched against your will?
		If yes, do you want to talk about it? ☐ YES ☐ NO Have you had counseling regarding it? ☐ YES ☐ NO
☐	☐	Do you smoke cigarettes? How many packs per day? _____ How many years? _____
☐	☐	Do you use street drugs? Which ones? _____
☐	☐	Have you had any alcohol, street drugs, or other mind-altering substances in the last 24 hours?
☐	☐	Have you had a new sexual partner(s) in the past 12 months?
☐	☐	Have you been tested for Sexually Transmitted Infections recently? If yes, when: _____
☐	☐	Have you ever had a Sexually Transmitted Infection? If yes, when: _____
		Check all that apply
		☐ Chlamydia ☐Gonorrhea ☐Trichomonas ☐PID ☐Herpes ☐Genital warts/HPV ☐HIV
		☐ Hepatitis ☐Syphilis ☐Other:_____
☐	☐	Would you like to be tested today for Sexually Transmitted Infections?
☐	☐	Do you have a current vaginal infection or symptoms?
☐	☐	Do you have a current urinary tract/bladder infection or symptoms?
☐	☐	Any other symptoms you are concerned with? If yes, describe: _____

MEDICAL HISTORY

Have you had any of the following medical conditions?

	YES	NO		YES	NO
Abnormal Pap Smear			Hepatitis, liver disease, or jaundice		
Colposcopy and/or treatment			High blood pressure		
Anemia/low blood iron			High cholesterol		
Asthma, other chronic lung disease, or apnea			Immunodeficiency disease (e.g. HIV)		
Bleeding or clotting disorder			Kidney infection or kidney problems		
Blood clots in vein, leg, or lung			Mental Illness		
Blood transfusion			Migraine headaches		
Breast disease of breast lump			Pelvic infection		
Cancer			Rheumatoid arthritis, Lupus, and/or other auto immune disorder		
Chemical dependency			Seizures or Epilepsy		
Diabetes or hypoglycemia			Chronic/long-term steroid use in the last 6 months (e.g. Cortisone, Prednisone)		
Do you weigh more than 200 pounds?			Suicide Attempt		
Gallbladder problems			Surgery or problems with uterus, ovaries, or fallopian tubes (e.g. Fibroids)		
Has a father or brother who had a heart attack or stroke before age 55?			Tuberculosis		
Has a mother or a sister who had a heart attack or stroke before age 55?			GERD or other stomach/intestine problems		
Heart surgery, significant heart murmur, or other heart problem			Other:		

Nurse Notes:

To the best of my knowledge, this information is complete and correct.

Patient Signature: _____ **Date:** _____

Nurse Signature: _____ Date: _____

Reviewed by physician:

_____
Initial and Date